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THE VENEREAL HISTORY: TRUTH OR FICTION

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HISTORY-TAKING at the best of times is always a difficult business. In some cases memories have to be jogged by skilful questioning, while in others of a more imaginative turn the use of suggestion has to be rigidly curtailed. In the case of the venereal patient this readiness to tell the truth and more is rarely met with, and during the course of five years clinic practice I have been struck by the reluctance of the average venereal patient to give a correct account of the time and manner of his infection, and this in spite of the fact that he more than any other type of patient is usually in a position to do so.

In all venereal diseases clinics there are in use printed questionnaires, the answers to the questions being filled in by the doctor in the appropriate spaces. These, though varying in details, are in the main similar as to the information they seek to obtain. In my clinic I employ one originated by Colonel L. W. Harrison, D.S.O. for use in his clinic at St. Thomas's Hospital. In this the order in which the questions are to be put is logical, and seems to be intended to put the patient at his ease by postponing the "awkward" enquiries to the end of the interview. But the best printed form in the world can only be a bare indication as to how the history is to be taken, and it is to a short description of some methods that I have found successful that I intend to devote these few paragraphs.

In the first place it cannot be too strongly urged that the patient be treated as a patient and not as a penitent or a prisoner, and the first remark of the doctor should be an invitation to sit down. Any unnecessary standing suggests the dock or the orderly room, whereas what is to be aimed at during this first interview, even in the busiest of clinics, is to create the atmosphere of a private consulting room. This invitation to sit down will also let the patient know that the doctor intends to spend some time over his case, in spite of the numbers of "old

cases" which he has seen from the waiting-room, apparently to him rushing in and out of the consulting-room door. He is next asked what he is complaining of. Often as not he anticipates this enquiry by an account of the last risk he has run, a complete denial of any past misbehaviour, or more often still by a protestation that he "can't understand how it has happened." These answers all suggest that many a patient finds it hard to get the idea out of his head that he is appearing before some sort of a tribunal, and that a plea of guilty or not guilty is the first statement required of him. I always counter these confessions or protestations with some remark to the effect that it does not matter about that for the moment, and continue to ask him to tell me what is troubling him. The usual reaction to this question is some attempt to undress and display the offending organ, due probably to some extent to an incoherence begotten of nervousness, but largely, I think, to a wish to get over quickly what is to many the most trying part of the interview, namely, the displaying of his "private parts" to the doctor. When he has been restrained from doing this, he is questioned about his past history, whether he has ever had anything wrong with him of this sort before, and, if he is noticeably nervous, asked about his general health in the past, a topic which I find most patients are keen to talk about. This done, he is asked how long it is since his last sexual intercourse, and the approximate dates of any other risks of exposure to infection that he has run in the course of the previous three months. Whatever may be the patient's answer to these questions, even though it amount to a palpably false denial of having run any risk at all, it should be accepted absolutely and without comment. Any attempt then, no matter how well meant, to persuade him to tell the truth will usually not succeed in its object, and will often have the effect of strengthening his determination to stand by his original story, false though it may be.

In the printed questionnaire that I use, the query "Nature of consort?" next occurs. This question is often used to elicit the information as to whether the consort was of professional or amateur status. In my opinion these particulars are relatively unimportant, and beyond the fact that they may give the doctor some small

idea of the strength of " the oldest profession " in his district, they do not seem to serve any useful purpose. The question, too, usually gets a false answer. Younger men tend to deny having had anything to do with a prostitute, regarding it as a slight on their attractions that it be thought that they had to pay for what they wanted, while the elderly man, brought up to regard prostitutes as the only " fair game," will often make out that his consort was one, though in fact she may turn out later to have been his housekeeper or an old acquaintance. It is important though that the doctor should know whether the woman was a total stranger or not, as if she is known to the patient, it will be worth while later trying to persuade him to get her to see a doctor.

The examination of the patient is next accomplished, and search is made for the gonococcus or the treponema. Not until the presence of either of these organisms has been demonstrated or the serological test of his blood been returned as positive, should the patient be told of the nature of the disease from which he is suffering. In the case where he has previously denied having run any risk of infection whatever, and where irrefutable evidence of acquired venereal disease has been forthcoming, I tell him quite plainly what is the matter with him and of the manner in which the disease is usually acquired, adding that, though it is theoretically possible that in his case the disease might have been acquired innocently, I have never come across a similar case where it has been so. The result of this remark will often be an admission of a past risk ; if not, the subject is best dropped with a remark to the effect that the knowledge of the exact date when the disease was acquired would help one in determining the best form of treatment. The American author of an otherwise excellent book on gonorrhœa employs an extraordinary method of getting the truth from these cases. To use his own words, he " tells the patient of some recent imaginary sexual lapse of his own," and claims that the result of this is " that the patient will become both confidential and boastful, and will shatter the mystery as to the source of his infection." He also states that " on the doctor raising the curtain upon his own supposed moral turpitude, a strong bond of friendship at once is engendered, upon the altar of which the patient offers his innermost secrets." I do not think that such

heroic measures will ever be found necessary on this side of the Atlantic.

In my experience patients who do not tell the truth during their first interview will almost invariaby do so later, provided that their original story is not crudely dismissed as impossible. The doctor's attitude should be to give the patient the idea that he will get more effective treatment if the exact date of his infection is known, and that beyond wanting to get to know that fact, the doctor has no interest in further details. Many is the time that this attitude on my part has resulted in the patient prefacing a further interview with : " As a matter of fact, doctor, I don't think I made myself clear last time." Then follows the truth.

I am convinced that the average venereal patient is often to some extent mentally unstable when he first sees the doctor, and is nearly always very much on his defence. He often as not has the idea that he is a social outcast, and wishes at all costs to appear not quite so bad as he feels he is. As well as this, he is filled with fear that the knowledge of his condition will become public property, and he is often apprehensive that the pain of his treatment will be more than he can bear. His knowledge of venereal disease is largely culled from terrifying accounts in " Health " magazines, and frightening stories with which old patients regale him in the waiting-room, taking a sadistic pleasure in describing to him with lurid falsehood the agonies he is to undergo during treatment. All these thoughts result in making him a thoroughly unreliable witness, and, unless his story fits in with the clinical findings, it is as well to ignore it at the first visit and usually later the truth will out.

In dealing with women I have found that it is necessary to be less inquisitive still, and, unless the patient introduces the question herself, I make a point of never alluding to the " risk " during the first interview. I note what she complains of, examine her, and, having established a diagnosis, tell her of the nature of her trouble. As most of my patients come with an introduction from husband or consort, or are sent to the clinic by their doctors with an explanatory note, it is usually not necessary to ask any awkward questions. In those cases where female patients come up on their own initiative, I content myself with asking them if they

have any idea of the date they were infected, giving them the idea at the same time that this knowledge will make it easier for me to decide on the form of treatment best suited to their particular trouble.

I do not believe that the duty of taking personal histories should ever devolve upon sisters or nurses. Apart from the fact that in my experience women do not show any more readiness to confide in members of their own sex, the practice, I think, is a bad one, as by duplicating the number of personal interviews, the patient's ordeal is made doubly difficult at a time when everything should be done to make it easier. In some large clinics the personal history is taken by a member of the Lady Almoner's department, and is laid before the doctor when he interviews the patient. Although this system appears to work well at St. Thomas's Hospital, due, I think, to a quite exceptional type of almoner, I do not think the practice is to be recommended as a general rule. After all, the patient has come to see a doctor about her trouble, and the more this personal relationship can be stressed, even in a public institution, the greater will be her confidence and the more wholeheartedly will she co-operate in the working out of her cure.

In conclusion, I do not think it will be amiss here to point out the existence of two problems which sometimes arise after the diagnosis of venereal disease has been established. A married man admits to having run an extra-marital risk, say, two months before, and it transpires that he has since then had intercourse with his wife. When the advisability of getting his wife examined is pointed out to him, he sometimes not unnaturally remarks that such a course would " break up the home." Here, again, I do not believe in using one's powers of persuasion during the first interview. I tell him the facts and leave it at that, and in most cases, on thinking things over, he decides to do the only right thing. On rare occasions one comes across the type of man who usually through stupidity refuses to say anything to his wife at all. With this type, if he persists in his attitude for longer than a few days, I believe in being quite brutal. I point out to him the constant danger of reinfection to himself, the danger to his children, and that, if his wife is infected, it is all bound to come out in the end with the added reproach, " Why didn't you tell me before it was

too late ? " The cases in which these selfish arguments have to be used are few and far between, but I have rarely known them to fail.

One is constantly hearing and reading of how careful one should be not to stress the serious after-consequences of syphilis. One is told of the results of syphilophobia, and how they drive the sufferer to the asylum or the gas-oven. My feeling, however, is that these statements require some qualification. So long as the patient is assiduous in attending for treatment, everything should be done to induce in him a feeling of cheerful optimism ; if he becomes at all anxious about himself he should be reassured of his complete safety so long as he carries out orders, and it should be impressed on him that it is only people who neglect their treatment who run the risk of future trouble. At the same time, in the case of the persistent defaulter from treatment, I find that a straight talk on the risks he is running will often bring him to his senses, and sometimes in particularly stubborn cases it does no harm to enlarge somewhat on syphilitic paralysis and insanity, the complications *par excellence* of the insufficiently treated case. Syphilophobiacs are " rare birds " in asylums, general paralytics are legion.

I hope that these few points will be of some use to those who are called upon to treat venereal disease, and that to some extent they will be an answer to my professional colleagues who sometimes ask, " How on earth did you get it out of him ? "